



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

November 8, 2006

Federal Express: 8430 8394 7817

Greg McCoy, Sole Proprietor
Aging with Grace Adult Care Home, Inc.
495-497 Pleasant Place
Moscow, ID 83843

COPY

Re: Revocation of Residential Care or Assisted Living Facility License
#RC-786 Aging with Grace Adult Care Home, Inc.

Dear Mr. McCoy:

Please accept this notice pursuant to Idaho Code section 39-3345 and IDAPA 16.03.22.940.02.a, 16.03.22.940.02.b, 16.03.22.940.02.f. and 16.03.22.940.02.r, that the residential care facility license #RC-786 for Aging with Grace Adult Care Home, Inc.; located at 495-497 Pleasant Place; Moscow, Idaho; 83843 is being revoked effective **December 6, 2006** based on Department findings from surveys conducted on August 25, 2006 and October 18, 2006.

On August 25, 2006, a standard health care survey was conducted at Aging with Grace Adult Care Home, Inc. It was determined during the survey that the facility was not in substantial compliance with the provisions of Idaho Code 39-3301 *et seq.*, the Idaho Residential Care or Assisted Living Act, and the rules governing Residential Care or Assisted Living Facilities.

- The facility was issued a core issue deficiency for inadequate care due to the failure to obtain emergency services for a resident who became unresponsive and for failure to develop and implement negotiated service agreements that included behavioral management plans.
- The facility was issued a second core issue deficiency for operating for more than 30 days without a licensed administrator.

In response to the August 25, 2006 survey, the facility failed to provide an acceptable plan of correction for core issue deficiencies and failed to provide acceptable evidence of resolution of punch list issues within 30 days of the exit conference as required by IDAPA 16.03.22.130.08 and IDAPA 16.03.22.130.09.

On October 18, 2006, a monitoring survey and a complaint investigation were conducted at Aging with Grace Adult Care Home, Inc. As a result of this survey and complaint investigation,

it was determined for the second time that facility was not in substantial compliance with the provisions of the Idaho Residential Care or Assisted Living Act, and the rules governing Residential Care or Assisted Living Facilities.

- The facility was issued another core issue deficiency for inadequate care due to the failure to obtain emergency services and for the failure to develop and implement negotiated service agreements that included behavioral management plans (repeated core issue deficiency).
- The facility was also issued a second core issue deficiency for allowing the facility to operate more than 30 days without a licensed administrator (repeated core issue deficiency). As of October 18, 2006, the facility had been operating for a total of one year, six months, and 19 days without a licensed administrator.

A detailed report of the finding leading to the determination of noncompliance is enclosed.

In addition, the October 18, 2006 survey found Aging with Grace Adult Care Home, Inc. had failed to obtain background checks for new employees; failed to provide general orientation training to new employees; failed to provide employees with specialized training on how to care for residents in the facility who had Alzheimer's/dementia and mental illness; failed to ensure at least one staff working in the facility was CPR certified; and allowed unlicensed staff to assist with medications without having the licensed nurse delegate this responsibility or assure unlicensed staff were competent to assist with those medications.

A previous standard survey conducted on November 16, 2004 found similar issues, including: a lack of nursing assessments of residents; failure to train staff; failure to ensure staff who assisted with medications had been delegated this task by the nurse; and a lack of cardio-pulmonary resuscitation (CPR) certification and first aid training for staff.

On three (3) consecutive surveys, November 16, 2004; August 25, 2006; and October 18, 2006; the Department has found deficiencies which indicate an inability of Aging with Grace Adult Care Home, Inc. to deliver adequate care or services to the residents living in the facility.

Additionally, on November 1, 2006, an inquiry to the Secretary of State revealed that Greg McCoy had been the sole owner of Aging with Grace Adult Care Home, Inc. since June of 2006. Residential Care Facility License #RC-786 was originally issued on April 16, 2004 to Aging with Grace Adult Care Home, Inc. with ownership Dawn McCoy 50% and Greg McCoy 50%. The 2005 Annual Report and Application for Renewal of Residential Care Facility License, dated October 21, 2005, amended ownership to Annette Holderman (33.3%), Dawn McCoy (33.3%) and Greg McCoy (33.3%). License #RC-786 was issued for Aging with Grace Adult Care Home, Inc. with this ownership structure for January 1, 2006 through December 1, 2006. No license has been issued for Aging with Grace Adult Care Home, Inc. with Greg McCoy as the sole proprietor. Refer to IDAPA 16.03.22.105.01, 16.03.22.120.01, 16.03.22.120.03, and 16.03.22.120.04.

Greg McCoy, Sole Proprietor
November 8, 2006
Page 3 of 3

You are also hereby notified, effective immediately, that the following enforcement actions are imposed:

1. **A ban on all new admissions pursuant to IDAPA 16.03.22.920. The ban on all admissions shall be in effect upon receipt of this notice and shall remain in effect until removed by the Department.**
2. **Should you choose not to abide by this condition, the Department will take action to summarily suspend the facility's license and transfer residents under IDAPA 16.03.22.900.01.**

You may contest this decision to revoke the facility's license by filing a written request for administrative review pursuant to IDAPA 16.05.03.300 **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Randy May
Deputy Administrator
Division of Medicaid-DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036**

If the facility fails to file a request for administrative review within the 28-day time period, this decision shall become final.

Should you elect to voluntarily relinquish your facility license, please contact me at (208) 334-6626 to coordinate an orderly transfer of the residents.

Sincerely,



DEBRA RANSOM, R.N., R.H.I.T.
Chief

DR/sm

Enclosure

c: Randy May, Deputy Administrator, Division of Medicaid
Jamie Simpson, Q.M.R.P., Supervisor, Residential Community Care Program
Lisa Deyoe, R.N., R.N. Manager, Region II Medicaid Services – DHW
Willard Abbott, Deputy Attorney General

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R786	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/18/2006
NAME OF PROVIDER OR SUPPLIER AGING WITH GRACE ADULT CARE HOMES, IN			STREET ADDRESS, CITY, STATE, ZIP CODE 495-497 PLEASANT PLACE MOSCOW, ID 83843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{R 000}	Initial Comments Surveyor: 21595 The following deficiencies were cited during the monitoring survey and complaint investigation of your facility. The surveyors conducting the survey were: John Wingate, RN. Team Coordinator Health Facility Surveyor Patrick Hendrickson, RN. Health Facility Surveyor Survey Definitions: BMP = Behavior Management Plan MAR = Medication Administration Record NSA = Negotiated Service Agreement	{R 000}			
{R 004}	16.03.22.215.03 Licensed Administrator Requirement - 30 Days The facility may not operate for more than thirty (30) days without a licensed administrator. This Rule is not met as evidenced by: Surveyor: 21595 Based on interview and record review it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations of the facility for a period of 30 days or more. During preparation for the monitoring survey conducted on 10/17/06, a review of the Bureau of Occupational Licenses for Residential Care Administrators, documented the license of the administrator of record expired on 3/30/05.	{R 004}			

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

FU8W12

If continuation sheet 1 of 12

Bureau of Facility Standards

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{R 004}	Continued From page 1 On 10/17/06 at 11:00 a.m., the facility's manager confirmed the facility had been without a licensed administrator since 3/30/05. On 10/17/06 at 11:18 a.m., the facility's owner stated the former administrator was no longer employed by the facility as of 5/30/05 or 5/31/05. He confirmed the facility had been without a licensed administrator for 1 year 6 months and 19 days. The facility had operated for more than 30 days without a licensed administrator responsible for day-to-day operations. This is a repeat core deficiency from the standard survey done on 8/24/06.	{R 004}			
{R 008}	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Surveyor: 21595 Based on interview, observations and record review it was determined the facility failed to provide emergency intervention with a change in a resident's condition for 1 of 2 sampled residents (#2). The facility also failed to develop a BMP for 1 of 2 sampled residents (#2). Additionally, the facility failed to develop UAI's and NSA's to identify and describe residents needs for 2 of 2 sampled residents (#1 and #2). Further, the facility failed to provide adequate training, staffing, and nursing services required to	{R 008}			

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{R 008}	<p>Continued From page 2</p> <p>meet the needs of the residents for supervision, first aid, assistance and monitoring of medications and provide a safe living environment.</p> <p>The findings include:</p> <p>I. Emergency Intervention</p> <p>A. Review of Resident #2's record on 10/17/06 revealed the resident was admitted on 4/26/04 with diagnoses that included dementia and coronary artery disease.</p> <p>A complaint received at the Bureau of Facility Standards stated "on 9/9/06 a staff member noticed an identified resident (Resident #2) had a blackened eye when he rose from bed, and the eye was cloudy. The identified resident was not taken to the physician to have the eye evaluated."</p> <p>Review of the facility's Incident and Accident log on 10/17/06 revealed no documentation of the incident. Further, the facility's Policies and Procedures documented "whenever an occurrence or event leads to unfortunate happening to a resident an Incident/Accident Report must be completed."</p> <p>Review of Resident #2's record on 10/17/06 revealed no documentation of the incident.</p> <p>Review of the nursing notes on 10/17/06 revealed no documentation of the incident and there was not a nurse on staff at the time of the incident.</p> <p>Further review of the facility's Policies and Procedures documented that "residents will receive appropriate emergency care" and "When it is apparent that a resident is in need of medical</p>	{R 008}			

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{R 008}	<p>Continued From page 3</p> <p>help, the staff member will call the ambulance, 911."</p> <p>On 10/17/06 at 11:00 a.m., the house manager stated the identified resident did have a blackened eye when he rose from bed on 9/9/06. She confirmed the identified resident (Resident #2) was not taken to a medical professional to have his eye evaluated. Further, she stated that no incident report or a investigation of the incident was done. She further confirmed that she did not report the incident to the Bureau of Facility Standards as this was a reportable incident.</p> <p>On 10/17/06 at 1:00 p.m., the owner stated, the identified resident did had a blackened eye that was noticed on 9/9/06. He confirmed the identified resident was not taken to a medical professional to have the eye evaluated and there was no facility nurse on staff at the time of the incident to evaluate the eye. Further, he did not know if an incident report or an investigation of the incident was done. He further stated that he did not know if the incident was reported to the Bureau of Facility Standards as this was a reportable incident.</p> <p>On 10/17/06 at 1:40 p.m. a caregiver stated, the identified resident did have a blackened eye that was noticed on 9/9/06. He confirmed the identified resident was not taken to the physician to have the eye evaluated and there was no facility nurse on staff at the time of the incident to evaluate the eye.</p> <p>B. Further review of the complaint on 10/16/06 received at the Bureau of Facility Standards stated an employee found an identified resident, (Resident #2) on the floor at 2:00 a.m. on the night of 9/17/06. She called the owner for</p>	{R 008}			

Bureau of Facility Standards

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{R 008}	<p>Continued From page 4</p> <p>assistance, as it takes two people to get the resident off the floor. The owner told the staff member to leave the resident on the floor until staff arrived at 6:00 a.m.</p> <p>On 10/17/06 at 10:40 a.m. the employee that was on duty at the time of the incident stated, "I heard a thud and the resident, (Resident #2) was found on the floor and at that time the resident was able to get back into bed by himself, but later that morning, at about 2:00 a.m., Resident #2 fell again, and was not able to get up off the floor by himself or with my help, so I called the owner. He told me to leave Resident #2 on the floor until change of shift at 6:00 a.m. another caregiver helped me to get the resident back to bed." She confirmed the resident laid on the floor for 4 hours.</p> <p>On 10/17/06 at 11:00 a.m., the house manager confirmed the resident was left to lay on the floor from 2:00 a.m., until 6:00 a.m., after Resident #2 was found on the floor and would not get off the floor by himself or with the assistance of the staff member on duty. She also confirmed that a medical evaluation was not provided to the resident to see if the resident was injured or was suffering from an acute medical problem.</p> <p>On 10/17/06 at 1:00 p.m., the owner stated the resident laid on the floor from 3:30 a.m., until 6:00 a.m. He also confirmed that no medical evaluation was provided to the resident to see if the resident was injured or he was suffering from an acute medical problem.</p> <p>Review of the facility's Incident and Accident log on 10/17/06 revealed no documentation of the incident. Further, the facility's Policies and Procedures documented "whenever an</p>	{R 008}			

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{R 008}	<p>Continued From page 5</p> <p>occurrence or event leads to unfortunate happening to a resident an Incident/Accident Report must be completed."</p> <p>Review of Resident #2's record on 10/17/06 revealed no documentation of the incident.</p> <p>Review of the nursing notes on 10/17/06 revealed no documentation of the incident and there was not a nurse on staff at the time of the incident.</p> <p>Further review of the facility's Policies and Procedures documented that "residents will receive appropriate emergency care" and " When it is apparent that a resident is in need of medical help, the staff member will call the ambulance, 911."</p> <p>II. Behavior Management</p> <p>Review of Resident #2's record on 10/17/06 revealed the resident was admitted on 4/26/04 with diagnoses that included dementia and coronary artery disease.</p> <p>Further review of the resident's record revealed no NSA or UAI or documented evidence of a BMP.</p> <p>The resident's record contained progress notes which were reviewed on 10/17/06. The notes revealed the resident had a history of being angry, violent, cussing and often refused cares or to get out of bed.</p> <p>On 10/17/06 at 10:50 a.m., a caregiver stated the resident at times was angry and could be violent and often refused cares and refused to get out of bed at times.</p>	{R 008}			

Bureau of Facility Standards

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{R 008}	<p>Continued From page 6</p> <p>On 10/17/06 at 1:00 p.m. the owner confirmed the resident's NSA or UAI was not developed and there was no BMP to help guide staff on how to deal with the resident's behavior's.</p> <p>III. NSA/UAI</p> <p>1. Review of Resident #1's record on 10/17/06 revealed the resident was admitted on 5/30/06 with a diagnoses of cerebral vascular accident and dementia.</p> <p>Further review of the resident's record revealed no documented evidence of a NSA or UAI.</p> <p>2. Review of Resident #2's record on 10/17/06 revealed the resident was admitted on 4/26/04 with diagnoses that included dementia and coronary artery disease.</p> <p>Further review of the resident's record revealed no documented evidence of a NSA or UAI.</p> <p>On 10/17/06 at 11:00 a.m., the house manager confirmed that she had not developed NSA's for Residents #1 and #2 and stated that this was her duty but had not done so due to illness.</p> <p>Surveyor: 22515</p> <p>IV. Staffing</p> <p>Review of the facility's policy documented the facility did not develop written staffing policies and procedures based on the numbers of residents, residents needs, and configuration of the facility.</p> <p>This resulted in the facility failing to employ</p>	{R 008}			

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{R 008}	<p>Continued From page 7</p> <p>sufficient numbers of staff at all times to meet the needs of the residents.</p> <p>Review of the complaint on 10/16/06 received at the Bureau of Facility Standards stated an employee found an identified resident, (Resident #2) on the floor at 2:00 a.m. on the night of 9/17/06. She called the owner for assistance, as it takes two people to get the resident off the floor. The owner told the staff member to leave the resident on the floor until staff arrived at 6:00 a.m.</p> <p>Review of September and October time sheets documented that only one caregiver was routinely scheduled on 10:00 p.m. - 6:00 a.m., shift.</p> <p>On 10/17/06 at 9:55 a.m., an interview with a caregiver revealed that the she was working on night shift about a month ago. Around 2 a.m., the caregiver heard a loud thump and went into the residents room and found Resident #2 on the floor. She couldn't get the resident up off the floor, and she was the only one working that night. The caregiver called the owner but the owner wouldn't come in to help her. The resident slept on the floor from 2 a.m., till around 6:00 a.m., when morning shift came on and helped her get the resident up and back into his bed. The caregiver further talked about not feeling safe working alone with two of the residents(Resident #2 and a resident that was not part of the selected review). She was worried that if either of the residents fell she wouldn't be able to get them up on her own.</p> <p>On 10/17/06 at 11:00 a.m., the house manager confirmed that there are two residents in the facility that required two person assist if they fall.</p>	{R 008}			

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{R 008}	<p>Continued From page 8</p> <p>Review of Resident #2's record on 10/17/06 revealed no documented evidence of a NSA or UAI to identify residents needs.</p> <p>V. Nursing Services</p> <p>During the initial standard survey on 8/25/06 it was confirmed that the facility did not have a contracted licensed professional nurse available to address changes in the residents health or mental status and to review and implement new orders prescribed by the residents health care provider.</p> <p>On 10/17/06 the nurses employee file documented she was hired on 9/25/06.</p> <p>On 10/17/06 a document titled " Nursing Responsibilities" that was developed by the current licensed professional nurse was reviewed. The nursing responsibility's included: Develop nursing care plans for each resident and delegate nursing care to staff. Complete a comprehensive nursing assessment at the time of admission and every 90 days thereafter. The nurse will inventory medications each month, dispose of outdated medications and medications no longer in use.</p> <p>On 10/17/06 review of 2 of 2 caregiver personnel files show no documentation that they received delegation from the facility's licensed professional nurse.</p> <p>On 10/17/06 and 10/18/06 2 of 2 caregivers were observed assisting residents with medications.</p> <p>On 10/18/06 at 7:15 a.m., during a phone interview with the licensed facility nurse she</p>	{R 008}			

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{R 008}	<p>Continued From page 9</p> <p>stated, "I have no written or signed nursing contract with [name of facility]." She also said that she had "done medication delegation on some, but not all non- licensed personnel, and was "not on call 24 hours a day for the facility."</p> <p>On 10/17/06 at 10:00 a.m., review of Residents #1 and #2 records revealed they did not contain nursing assessments done by a licensed professional nurse.</p> <p>On 10/17/06 at 10:50 a.m., the house manager stated the nursing assessments were missing in some of the charts. She stated the assessments were in the office however she could not produce the assessments during the time of the survey.</p> <p>On 10/17/06 observation of Resident #1's medications revealed blister packs dated June and July 2006. The blister packs contained unused medications, that shouldn't have been retained at the facility for more than 30 days.</p> <p>On 10/18/06 at 9:38 a.m., an open medication box with pill bottles lying around it was observed sitting unsupervised on the top of the kitchen stove.</p> <p>On 10/19/06 The facility owner, during a phone conversation, stated "we haven't had a contracted licensed professional nurse for many months until we hired one on September 25, 2006."</p> <p>VI. Staff Training/Orientation</p> <p>Review of residents charts and resident matrix on 10/17/06 documented 3 of 5 residents had a diagnosis of alzheimer/dementia Residents (#1</p>	{R 008}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{R 008}	<p>Continued From page 10</p> <p>#2 and #5). 1 of 5 residents had a diagnosis of mental illness (Resident #3).</p> <p>On 10/17/06 at 10:20 a.m., in an interview with caregiver #1, working that day, confirmed she had been working alone without out cardiopulmonary resuscitation (CPR)certification, first aid certification, delegation from the licensed professional nurse, or specialized training to work with residents with dementia.</p> <p>Review of personnel charts on 10/17/06 at 1:55 p.m., documented that 2 of 2 personnel (Caregiver #1 and caregiver #2) worked that day had no evidence of CPR, first aid certification, criminal background check, delegation from the licensed professional nurse, 16 hours of initial orientation, specialized training for alzheimer/dementia or mental illness training.</p> <p>The facility failed to obtain emergency intervention for Resident #2 when the resident was found on the floor the night of 9/17/06. Further, the facility did not develop UAI'S or NSA's for Residents #1 and #2 to direct staff in the care of the residents. Additionally, the facility failed to develop a BMP for Resident #2 to provide guidance to personnel in their provision of care and services to meet the needs of the resident for inappropriate and unsafe behaviors. Additionally the facility failed to schedule at least one direct caregiver with certification in first aid and CPR in the facility at all times. The facility did not have documentation on file that the facility provided proper orientation and training in providing care for residents with mental illness and dementia. The facility further failed to provide or document a minimum of 16 hours of initial orientation training. The facility failed to ensure</p>	{R 008}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R786	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/18/2006
NAME OF PROVIDER OR SUPPLIER AGING WITH GRACE ADULT CARE HOMES, IN			STREET ADDRESS, CITY, STATE, ZIP CODE 495-497 PLEASANT PLACE MOSCOW, ID 83843		
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{R 008}	Continued From page 11 that a licensed nurse was available to address changes in the residents health or mental status. The facility failed to ensure that a licensed nurse visited the facility to assess resident's health status when there was a change in residents condition. These failures resulted in inadequate care. These are repeat core deficiencies from the standard survey done on 8/24/06.	{R 008}			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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November 13, 2006

Greg McCoy, Owner
Aging With Grace Adult Care Homes, Inc
495-497 Pleasant Place
Moscow, ID 83843

FILE COPY

Dear Mr. McCoy:

On October 18, 2006, a complaint investigation survey was conducted at Aging With Grace Adult Care Homes, Inc. The survey was conducted by John Wingate, R.N. and Patrick Hendrickson, R.N. This report outlines the findings of our investigation.

Complaint # ID00001921

Allegation #1: An employee found an identified resident on the floor at 2:00 a.m., on September 17, 2006. She called the owner for assistance, as it took two people to get the resident off the floor. The owner told the staff member to leave the resident on the floor until staff arrived at 6:00 a.m.

Findings: Based on interview it was determined that an employee did find the identified resident on the floor at 2:00 a.m., on September 17, 2006. She called the owner for assistance, as it took two people to get the resident off the floor. The owner told the staff member to leave the resident on the floor until staff arrived at 6:00 a.m.

On October 17, 2006 at 10:40 a.m. the employee that was on duty at the time of the incident stated, "I heard a thud and the resident was found on the floor and at that time I was able to put him back to bed and then later that morning at about 2:00 a.m., he fell again, so I called the owner. He told me to leave him on the floor until change of shift at 6:00 a.m. another caregiver helped me to get the resident back to bed." She confirmed the resident laid on the floor for 4 hours.

On October 17, 2006 at 11:00 a.m., the house manager confirmed the resident was left to lay on the floor from 2:00 a.m., until 6:00 a.m., after he was found on the floor

and would not get off the floor by himself or with assistance. She also confirmed that a medical evaluation was not provided to the resident to see if the resident was injured or was suffering from an acute medical problem.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for failure to protect residents from inadequate care. The facility was required to submit a plan of correction.

Allegation #2: An identified resident's daughter who was the residents POA, was not called about an accident.

Findings: Based on interview it was determined the identified residents family member, who was the residents power of attorney (POA), was called about an accident.

On October 17, 2006 at 11:00 a.m., the house manager stated the identified resident's family member, who was the residents POA, was notified by the owner about the accident.

On October 17, 2006 at 1:00 p.m. the owner stated he had called the family member of the identified resident about the accident.

On October 17, 2006 the identified resident's family member, who was the residents POA, was called but no one was available.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation conducted on October 17, 2006.

Allegation #3: On September 9, 2006 a staff member noticed an identified resident had a blackened eye when he rose from bed, and the eye was cloudy. The Identified resident was not taken to the physician to have the eye looked at.

Findings: Based on interview it was determined that on the September 9, 2006 a staff member did notice that an identified resident had a blackened eye when he rose from bed, and the eye was cloudy. The Identified resident was not taken to the physician to have the eye evaluated.

On October 17, 2006 at 11:00 a.m., the house manager stated the identified resident did have a blackened eye when he rose from bed on September 9, 2006. She confirmed the identified resident was not taken to a physician to have the eye evaluated.

On October 17, 2006 at 1:00 p.m. the owner stated the identified resident did have a blackened eye that was noticed on September 9, 2006. He confirmed the identified

resident was not taken to the physician to have the eye evaluated and also stated there was no facility nurse on staff at the time of the incident to evaluate the eye.

On October 17, 2006 at 1:40 p.m. a caregiver stated, the identified resident did have a blackened eye that was noticed on September 9, 2006. He confirmed the identified resident was not taken to the physician to have the eye evaluated. He stated there also was no facility nurse on staff at the time of the incident to evaluate the eye.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for failure to protect residents from inadequate care. The facility was required to submit a plan of correction.

Allegation #4: There is a resident who weighs approximately 400 lbs. that fell last week. When staff called the owner for help he said he had an appointment and would come help get her up afterward.

Findings: Based on interview it was determined there was a resident who weighed approximately 400 lbs. and had fallen. When staff called the owner for help he did say he had an appointment and would come help get her up afterward. However, the owner did change his mind and come in and help get the resident up.

On October 25, 2006 at 9:30 a.m., the identified resident stated she had slid out of her chair and was unable to get up. She said she had no injuries and the caregiver was not strong enough to assist her back to her feet. She said the caregiver then called the owner and in 10 minutes he showed up to the facility and assisted her to her feet.

On October 25, 2006 at 1:30 p.m., a staff member stated the identified resident did slid out of her chair and was unable to get up off the floor without assistance. She said the resident had no injuries and she was not strong enough to assist the resident back to her feet. She said when she called the owner for help he did say he had an appointment and would come help get her up after the appointment but the owner showed in 10 minutes and assisted the resident back to her feet.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by assisting the resident back to feet within 10 minutes of the fall.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies. AND/OR Non-core issues were identified and included on the Punch List.

Dawn McCoy, Administrator
November 13, 2006
Page 4 of 4

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

A handwritten signature in black ink, appearing to read "John Wingate", with a stylized flourish at the end.

JOHN WINGATE, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

JW/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
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ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name <i>Aging with Grace Adultcare Homes</i> Administrator <i>none</i>	Physical Address <i>495-497 Pleasant Place</i> City <i>MOSCOW ID 83843</i>	Phone Number <i>208-882-1951</i> ZIP Code <i>83843</i>
Survey Team Leader <i>J. Wingate RN</i>	Survey Date <i>10-17-06</i>	

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	310.01	The facility used multi dose medication distribution system. (Repeat Punch)		
2	310.02	Unused, discontinued or out dated medications were kept in the facility for longer than 30 days. (Repeat Punch)		
3	630.01	The Facility did not have specialized training documented for Mental Illness. (Repeat Punch List)		
4	730.01.6	2 of 2 staff did not have criminal history clearance. (Repeat Punch)		
5	730.01.H	No documentation by the BO of delegation to un-licensed staff to assist with medications. (Repeat)		
6	711.08.C	Residents ongoing care records did not contain documentation of unusual events, such as incident, reportable incidents, accident, or the facilities response.		
7	730.01.F	Caregivers personnel files did not contain proof of CPR First aid or Medication certification.		
Response Required Date <i>11-17-06</i>			Signature of Facility Representative <i>[Signature]</i>	
			Date Signed	